Physical Form

Childs Name: ____

Age: _____________ Date of Birth: ___ /___ /___

Any Known Allergies: Yes/No. If yes, please list allergies:
____

Any Known Disabilities: Yes/No. If yes, please list any: ________________________

Physicians Statement of Health:

I certify that I have examined And have found no gross evidence of any abnormality that will keep him/her from participating in the Youth Sports Program.

Physicians Name: ____

Address: ____

Phone: __________________________

Signature: ____

Date: ______________________

(Must be for this Calendar Year, dated after April 1st)

MUST BE STAMPED